Khoury Chiropractic, Inc.

640 Washington Street
Dedham, MA 02026
(781) 329-3344

Wassim G. Khoury, D.C
Dawn-Marie Khoury, D.C., D.I.C.C.P.

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Khoury Chiropractic Inc.'s *Notice of Privacy Practices for Protected Health Information.*

Parent/Guardian Name Printed _____ Date _____

Patient/Guardian Signature _____

Witness Name Printed _____ Date _____

Witness Signature _____

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Name of Child: _____ Name of Parent: _____

Address: _____ Parent's Address (if different from child): _____

City: _____ State:_____ Zip: _____ City:_____ State:_____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Child's Date of Birth: _____ Age: ____ Sex: ☐M ☐F Email: _____

Name of Emergency Contact: _____ Phone Number of Emergency Contact: _____

# of weeks of Pregnancy with child: _____ Referred to This Office By: _____

Name of Primary Care Physician (Pediatrician): _____ PCP Phone: _____

Race: _____ Ethnicity: _____

List any concerns you have about your child's health:_____

YES	NO	**REGARDING PREGNANCY:**
☐	☐	Did your diet include sugar, white flour, or trans fats?
☐	☐	Did you have any back pain during pregnancy?
☐	☐	Did you consume any alcoholic beverages during pregnancy?
☐	☐	Did you smoke cigarettes, drink caffeine, or take medications?
☐	☐	Did you receive any vaccinations or shots?
☐	☐	Were you physically ill at any time?

List medications taken during pregnancy: _____
_____

YES	NO	**REGARDING LABOR/DELIVERY:**
☐	☐	Did you experience back pain during labor?
☐	☐	Did you experience a difficult or prolonged labor?
☐	☐	Was your delivery extremely rapid?
☐	☐	Was your baby's presentation head down?
☐	☐	Was your baby posterior or breech?
☐	☐	Was another individual supporting you during labor and delivery?

Did the delivery involve any of the following?

☐	☐	Forceps
☐	☐	Vacuum suction
☐	☐	C-section
☐	☐	Pulling or twisting of your baby
☐	☐	Pitocin (chemically induced labor)
☐	☐	Epidural

Where was your child delivered? ☐ Home ☐ Birthing Center ☐ Hospital

YES	NO	**NUTRITION:**
☐	☐	Did you breast feed your child? If yes, for how long? _____
☐	☐	Did your child have difficulty latching on?
☐	☐	Was your baby formula-fed? If yes, what type/brand of formula? _____
☐	☐	Were solid foods introduced before 6 months?

Did your baby's diet include the following **before 1 year old**?

☐	☐	Cow's milk
☐	☐	Soy
☐	☐	Sugar
☐	☐	Trans-Fats
☐	☐	Wheat/Grains
☐	☐	White Flour
☐	☐	Nuts
☐	☐	Corn

Does your child's diet include any of the following **currently?**

☐	☐	Cow's milk
☐	☐	Sugar
☐	☐	Artificial Sweeteners (Splenda, Nutrasweet)
☐	☐	Soda
☐	☐	White Flour
☐	☐	Grains or Wheat
☐	☐	Trans Fats (margarine, packaged foods, etc.)
☐	☐	Soy
☐	☐	Does you child have any allergies?

List any allergies (food or environmental): _____

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

EMOTIONAL HEALTH:

YES NO
- ☐ ☐ Does your child fail to follow directions?
- ☐ ☐ Is your child hyperactive?
- ☐ ☐ Does your child have difficulty socializing with others?
- ☐ ☐ Does your child often have "temper tantrums?"
- ☐ ☐ Does your child get frustrated easily?

Other behavioral problems: _____

MEDICAL HISTORY:

YES NO
- ☐ ☐ Has your child ever taken an antibiotic?

Number of antibiotic prescriptions: _____
Reason for antibiotics: _____

- ☐ ☐ Did your child receive any vaccinations?
- ☐ ☐ If yes, did your child present behavioral or physical changes after vaccination?
- ☐ ☐ Has your child ever been hospitalized?

Reason and date of hospitalization:

_____

- ☐ ☐ Has your child had any surgeries?

List surgeries: _____

- ☐ ☐ Exposure to ultrasound? How many and what was the medical reason?

_____

FAMILY HISTORY:

YES NO
- ☐ ☐ Do any other family members have health problems?

List siblings:
Brother(s): Age(s) _____
Sister(s): Age(s) _____

GROWTH AND DEVELOPMENT:

At what age did your child sit up? _____ months
At what age did your child crawl? _____ months
At what age did your child walk? _____ months
At what age did your child talk? _____ months

Child's Height and Weight **at Birth**:
Height: _____ Weight: _____
APGAR scores at birth: _____

Child's Height and Weight **at Last Physical**:
Height: _____ Weight: _____

List any concerns about your child's growth and development: _____

_____

List your child's current medications and/or Supplementation/vitamins: _____

_____

_____

PHYSICAL TRAUMA:

YES NO
- ☐ ☐ Did your child ever fall when learning to sit-up, stand, walk, run, ride a bike, play sports?
- ☐ ☐ Has your child ever fallen, tripped, or hit his/her head?
- ☐ ☐ Has your child ever fallen from a height greater than 2ft?
- ☐ ☐ Has your child ever broken a bone, dislocated or sprained a joint?
- ☐ ☐ Has your child ever been in a motor vehicle accident? Date of accident: _____
- ☐ ☐ Does your child carry a backpack greater than 15% of his/her body weight?
- ☐ ☐ Does your child spend more than 1 hr per day in front of the TV, video games, or computer?
- ☐ ☐ Did his/her mother ever fall when pregnant with this child?

HAS YOUR CHILD SUFFERED FROM ANY OF THE FOLLOWING HEALTH PROBLEMS?

YES NO
- ☐ ☐ Torticollis/Wry neck
- ☐ ☐ Reflux/vomiting
- ☐ ☐ Failure to thrive/difficulty gaining weight
- ☐ ☐ Difficulty turning head to one side
- ☐ ☐ Hyperactivity/ADD
- ☐ ☐ Ear Infections
- ☐ ☐ Difficulty Sleeping
- ☐ ☐ Bed Wetting
- ☐ ☐ Irritability
- ☐ ☐ Colic
- ☐ ☐ Frequent Colds
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Gas Pains
- ☐ ☐ Rashes/Eczema
- ☐ ☐ Milk/Lactose Intolerance
- ☐ ☐ Food sensitivities
- ☐ ☐ Allergies
- ☐ ☐ Asthma
- ☐ ☐ Headaches
- ☐ ☐ Learning Disorder
- ☐ ☐ Poor Posture
- ☐ ☐ Chicken Pox
- ☐ ☐ Pneumonia
- ☐ ☐ Whooping Cough (Pertussis)
- ☐ ☐ Measles
- ☐ ☐ Flu
- ☐ ☐ Diabetes
- ☐ ☐ Cancer, Leukemia
- ☐ ☐ Back pain
- ☐ ☐ Neck pain
- ☐ ☐ Autism/Autistic spectrum disorder
- ☐ ☐ Weight trouble/overweight
- ☐ ☐ Other_____

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

KHOURY CHIROPRACTIC, INC. POLICIES:

Our purpose at The Khoury Centre is to help as many people as possible achieve maximum health through chiropractic care, guidance, and education.

It is our policy that payments for all services are due at the time they are rendered and are not billed periodically to patients. Billing for patients' personal balances increases offices expenses resulting in higher costs of services. We accept cash, personal checks, and most credit cards.

As a courtesy to you we will bill your insurance company for their portion of the bill. All patients are expected to supply this office, in a timely manner, with any and all information necessary to file and bill your claims. Any checks sent to you from your insurance company for services rendered in this office must be brought into our office within 3 days.

It is understood and agreed that the amount paid to the Doctor for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Although unlikely, some patients may experience mild discomfort due to examination procedures. I hereby authorize the Doctor to examine and diagnose my child's condition, as he or she deems appropriate.

Parent/Guardian signature: _____ Date _____

CONSENT TO TREATMENT OF MINOR
(CHILD UNDER 18)

I hereby request and authorize the doctor(s) of The Khoury Centre to perform diagnostic tests and render chiropractic adjustments and other treatments as necessary to my child, the said patient.

This authorization also extends to all other doctors and trained office staff and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____
Parent/Guardian Name Printed Relationship to Patient

_____ _____
Patient/Guardian Signature Date

_____
Witness Signature

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Please read the following updated policies initial next to each notice and sign the bottom, in signing you acknowledge you have received and understand this notice. A copy can be provided upon request.

Note: Insurance may not always pay for everything, even some care that you or your health care provider have good reason to think you need. You may choose not to receive services that may cost additional charges due to non-coverage. In these cases of non-coverage where you have received specific treatments, you the patient are responsible for the balance.

INITIAL_____

PATIENT RESPONSIBILITIES

Insurance: As a patient, it is your responsibility to notify the Front Desk Office if and when there are changes to your insurance (ie. Change of insurance carriers). Failure to do so causes the office to bill the wrong insurance company resulting in non-payment. In the event this happens you, the patient, are responsible for any outstanding/non-covered costs. *We may try to rebill the new insurance but there are certain time limits put in place where this may not be possible if the date of service is outside of the allottable period.*

INITIAL_____

Appointment Policy: Please give the office 24 hours notice if you need to cancel or reschedule your appointment. **Any appointment not cancelled within 24 hours will be assessed a missed appointment fee of $65.**

INITIAL_____

_____ _____

Patient Signature Date

640 Washington Street
Dedham, MA 02026
(781) 329-3344

Wassim G. Khoury, D.C.
Dawn-Marie Khoury, D.C., D.I.C.C.P.